

**Small Business Program**  
**PPOBlue Benefit Summary**  
**PPOBlue Basic w/Incentive Rx**



PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
100%/80%	\$250/\$500	\$20/\$20 COPAY	\$75 COPAY

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate care. There is no requirement to select a Primary Care Physician (PCP) to coordinate care. Below are specific benefit levels that apply during your benefit period.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Period</b>	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
<b>Deductible Per Benefit Period</b>	\$250 Individual \$500 Family Aggregate	\$500 Individual \$1,000 Family Aggregate
<b>Payment Level</b> <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC after deductible	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
<b>Out-of-Pocket Limit</b> <i>Includes Coinsurance, certain exclusions may apply</i>	Not Applicable	\$5,000 Individual \$10,000 Family Aggregate
<b>Lifetime Maximum</b>	\$5,000,000/Individual	
<b>Ambulance</b>	100% PRC after deductible	80% PRC after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to an Accidental Injury</b>	Not Covered	Not Covered
<b>Diabetes Treatment</b>	100% PRC after deductible	80% PRC after deductible
<b>Diagnostic Services (including routine and pre-admission testing)</b> <i>Advanced Imaging (MRI, CAT scan, PET scan, etc.)</i>	100% PRC after deductible	80% PRC after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	100% PRC after deductible	80% PRC after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% PRC after deductible	80% PRC after deductible
<b>Emergency Room Services</b>	100% PRC after \$75 Copay – waived if admitted	
<b>Enteral Formulae</b>	100% PRC no deductible	80% PRC no deductible
<b>Hearing Care Services</b>	Not Covered	Not Covered
<b>Home Health Care</b> <i>Excludes Respite Care</i>	100% PRC after deductible	80% PRC after deductible
<b>Hospice</b> <i>Includes Respite Care</i>	90 visits/benefit period	
	100% PRC after deductible	80% PRC after deductible
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	100% PRC after deductible	80% PRC after deductible
<b>Infertility Counseling, Testing and Treatment</b> <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i>	100% PRC after deductible	80% PRC after deductible
<b>Maternity Includes Dependent Daughters</b>	100% PRC after deductible	80% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	100% PRC after deductible	80% PRC after deductible
<b>Mental Health Inpatient</b> ①	100% PRC after deductible	80% PRC after deductible
<b>Mental Health Outpatient</b> ①	100% PRC after \$20 Copay	80% PRC after deductible
<b>Office Visits</b> <i>Primary Care Physician</i> <i>Specialty Care Physician</i>	100% PRC after \$20 Copay 100% PRC after \$20 Copay	80% PRC after deductible 80% PRC after deductible
<b>Oral Surgery</b>	100% PRC after deductible	80% PRC after deductible
<b>Physical Medicine Outpatient</b>	100% PRC after \$20 Copay	80% PRC after deductible
----- 20 visits/benefit period		

PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
100%/80%	\$250/\$500	\$20/\$20 COPAY	\$75 COPAY

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Preventive Care</b> <i>Adult Preventive Care Schedule includes:</i> Routine Physical Exam Immunizations Colorectal Cancer Screening, routine and medically necessary Routine Diagnostic Screening Screening, Mammography Routine Gynecological Exam & Pap Test	100% PRC after \$20 Copay 100% PRC after deductible 100% PRC after deductible  100% PRC after deductible 100% PRC no deductible 100% PRC after \$20 Copay/no lifetime maximum	80% PRC after deductible 80% PRC after deductible 80% PRC after deductible  80% PRC after deductible 80% PRC after deductible 80% PRC no deductible/lifetime maximum
<i>Pediatric Preventive Care Schedule includes:</i> Routine Physical Exams Pediatric Immunizations  Routine Diagnostic Screening	100% PRC after \$20 Copay 100% PRC no deductible/lifetime maximum  100% PRC after deductible	80% PRC after deductible 80% PRC no deductible/lifetime maximum  80% PRC after deductible
<i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>		
<b>Private Duty Nursing</b>	100% PRC after deductible	80% PRC after deductible
	240 hours/benefit period	
<b>Skilled Nursing Facility Care</b>	100% PRC after deductible	80% PRC after deductible
	100 days/benefit period	
<b>Speech &amp; Occupational Therapy</b>	100% PRC after \$20 Copay	80% PRC after deductible
<i>Outpatient</i>	12 visits/benefit period per type of therapy	
<b>Spinal Manipulations</b>	100% PRC after \$20 Copay	80% PRC after deductible
	20 visits/benefit period	
<b>Substance Abuse Detoxification</b>	100% PRC after deductible	80% PRC after deductible
<b>Substance Abuse Inpatient Rehabilitation</b>	100% PRC after deductible	80% PRC after deductible
<b>Substance Abuse Outpatient</b>	100% PRC after \$20 Copay	80% PRC after deductible
<b>Surgical Expenses</b>	100% PRC after deductible	80% PRC after deductible
<i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>		
<b>Therapy and Rehabilitation Services</b>	100% PRC after deductible	80% PRC after deductible
<i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>		
<b>Transplant Services</b>	100% PRC after deductible	80% PRC after deductible
<b>Precertification Requirements for Inpatient Admissions</b>	Performed by Network Provider	Performed by Member
<i>No Penalty for Non-compliance. If Highmark Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.</i>		
<b>Condition Management</b>	Case Management, Blues on Call, and Disease State Management	

① State mandated benefits (30 inpatient days and 60 outpatient visits annually) **may** apply for serious diagnosis. Serious diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

<b>PRESCRIPTION DRUG</b>	<b>RETAIL PHARMACY</b>	<b>MAIL SERVICE PHARMACY</b>
<b>Deductible</b> ( <i>per benefit period</i> )	None	
<b>Prescription Drug - Prescription Drug Card</b> <i>Retail 31 day supply; Mail Order 90 day supply</i>	Three (3) different copay schedules are available (generic/brand names)	
<b>Formulary</b>	Incentive	
<b>Generic Substitution</b>	Soft -When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed	
<b>Out-of-Pocket Maximum</b>	Not Applicable	
<b>Claim Submission</b>	Pharmacy Files at Point-of-Sale	
<b>Non-Network Pharmacy</b>	Not Covered	
<b>PRESCRIPTION DRUG CATEGORIES</b>		
<b>Contraceptives</b> ( <i>oral and injectable</i> )	Covered	
<b>Fertility Agents</b>	Covered	
<b>Fluoride Products</b>	Covered	
<b>Insulin and Diabetic Supplies</b>	Covered	
<b>Smoking Deterrents</b> ( <i>prescription</i> )	Covered	
<b>Vitamins</b> ( <i>prescription</i> )	Covered	
<b>Weight Loss Drugs</b>	Covered	
<b>Allergy Serum</b>	Not Covered	
<b>Durable Medical Equipment</b>	Not Covered	
<b>Prescription Hair Growth Products</b>	Not Covered	
<b>CARE MANAGEMENT PROGRAMS</b>		
<b>Exclusive Pharmacy Provider</b>	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.	
<b>Quantity Level Limits</b> <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
<b>Managed Rx Coverage</b> <i>on certain drug therapies</i>	Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded..	
<b>Managed Prior Authorizations</b>	Applies on select high cost drugs.	